Adult and Teen Challenge Northern Indiana
Student Application Form

* = Required | ** Intake Rep will Fill Out

Prefix: (i.e., Mr, Ms, Miss, Mrs, Dr, Rev, etc.) _____
First Name* _____
Middle Name _____
Last Name* _____
Suffix (Jr., Sr., III, Esquire, etc.) _____
National ID (SSN)* _____ - ___ - _____
Date of Birth*Phone __ / __ / ____
Do you have a permanent address? Yes ___ No ___
Permanent Address Line 1 (Last Known Address) _____
Permanent Address Line 2 _____
City _____State _____Zip _____
E-mail _____
Phone Number 1 ( ) ____-_____

Notes (if you would like to explain any of your answers, you may do so in the Notes Sections)

_____
_____
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Support Contact Information

Support Contact No. 1 | **Is this person an Emergency Contact?*** Yes____ No ____

❑ Emergency Contact (place an X in the box if this person is your emergency contact)

Prefix: (i.e., Mr, Ms, Miss, Mrs, Dr, Rev, etc.) _____

First Name* _____

Middle Name _____

Last Name* _____

Suffix (Jr., Sr., III, Esquire, etc.) _____

Relationship* _____

Permanent Address Line 1 (Last Known Address) _____

Permanent Address Line 2 _____

City _____State _____Zip _____

E-mail _____

Phone Number 1 ( ) ____-_____

Phone Number 2 ( ) ____-_____

Other Phone ( ) ____-_____

Notes:_____

_____

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Demographic Information

Marital Status* Married ❑ Separated ❑ Divorced ❑ Engaged ❑ Girlfriend ❑

Use this area if you would like to give more information about your situation:_____

_____

_____

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Race* _____

Gender at Birth* Male ❑ Female ❑

Current Housing*

Permanent ❑ Temporary ❑ Shelter ❑ Homeless ❑ Incarcerated ❑

Eye Color* Black ❑ Blue ❑ Brown ❑ Gray ❑ Green ❑ Hazel ❑ Multicolor ❑
Amber ❑ Red ❑ Violet ❑

Primary Language* English ❑ Spanish ❑ Other: _____

Can you read English? Yes ❑ No ❑

Can you read another language? Yes ❑ No ❑ If yes, what language? _____

Can you write in English? Yes ❑ No ❑

Can you write in another language? Yes ❑ No ❑ If yes, what language? _____

Education Level Completed*

High School Graduate ❑ No Schooling ❑ Primary (Grades 1-6) ❑
Middle School (grades 7-8) ❑ High School ❑ High School but no Diploma ❑
High School or Diploma Equivalent (HSE/GED/etc) ❑ Some College ❑
Undergraduate Degree (AA/AS/etc) ❑ Undergraduate Degree (BA/BS/BBA/etc) ❑
Trade School Certification ❑ Masters (MS/MA/MsEd) ❑ Doctorate (PhD/EdD) ❑
Professional Degree (MD/DDS/DVM) ❑ Post Graduate ❑

Work

Work Skill(s)*

No Skill ❑ Trade Skills ❑ Professional ❑ Advanced Trade Skills ❑ Disabled ❑

Employed? Yes ❑ No ❑

If Yes, What was your start date? ___ / ___ / _____

Family Responsibilities

Number of Dependent Children: _____

Children Being Cared For: By family ❑ Foster Care ❑

Are you aware you will not generate any income while you are at this Center? Yes ❑ No ❑

Do you have a Driver's License? Yes ❑ No ❑

DL Number? _____

Additional Profile Information

Addiction Profile Type: 1. Drugs/Alcohol ❑ 2. Porn ❑ 3. Gambling ❑ 4. Self-Harm ❑
5. Tobacco/Nicotine ❑ 6. Food/Binge Eating ❑ 7. Screen Addiction ❑ 8. Other ❑

Substance Abuse 1

Drug Name:_____

Frequency of Use: Daily ❑ Weekly ❑ Monthly ❑ Yearly

Drug of Choice Yes ❑ No ❑

Addiction Start Date ___ / ___ / _____

Addiction End Date ___ / ___ / _____

How is/Was Drug Administered? Smoke ❑ Snort ❑ Intravenous ❑ Swallowed ❑

Other: _____

Substance Abuse 2

Drug Name:_____

Frequency of Use: Daily ❑ Weekly ❑ Monthly ❑ Yearly

Drug of Choice Yes ❑ No ❑

Addiction Start Date ___ / ___ / _____

Addiction End Date ___ / ___ / _____

How is/Was Drug Administered? Smoke ❑ Snort ❑ Intravenous ❑ Swallowed ❑

Other: _____

Substance Abuse 3

Drug Name:_____

Frequency of Use: Daily ❑ Weekly ❑ Monthly ❑ Yearly

Drug of Choice Yes ❑ No ❑

Addiction Start Date ___ / ___ / _____

Addiction End Date ___ / ___ / _____

How is/Was Drug Administered? Smoke ❑ Snort ❑ Intravenous ❑ Swallowed ❑

Other: _____

Please describe your non-drug or alcohol addictions: _____

_____

_____

_____

_____

Have you ever been in treatment for addiction before? Yes ❑ No ❑

How many times? _____

Date of last Treatment? ___ / ___ / _____

Previous Treatment 1

Program Type:

Recovery ❑ Prevention ❑ School Admin ❑ Detox ❑ Inpatient Short (<30 days) ❑

Inpatient Long (30-90 days) ❑ Outpatient ❑ Residential Recovery ❑

510 Intervention ❑ Intensive Aftercare ❑ OVWI ❑ Other _____

Treatment Start Date ___ / ___ / _____

Treatment End Date ___ / ___ / _____

Center Name _____

Notes (if you would like to explain any of your answers, you may do so in the Notes Sections)

_____

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Previous Treatment 2

Program Type:

Recovery ❑ Prevention ❑ School Admin ❑ Detox ❑ Inpatient Short (<30 days) ❑

Inpatient Long (30-90 days) ❑ Outpatient ❑ Residential Recovery ❑

510 Intervention ❑ Intensive Aftercare ❑ OVWI ❑ Other _____

Treatment Start Date ___ / ___ / _____

Treatment End Date ___ / ___ / _____

Center Name _____

Notes (if you would like to explain any of your answers, you may do so in the Notes Sections)

_____

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Previous Treatment 3

Program Type:

Recovery ❑ Prevention ❑ School Admin ❑ Detox ❑ Inpatient Short (<30 days) ❑

Inpatient Long (30-90 days) ❑ Outpatient ❑ Residential Recovery ❑

510 Intervention ❑ Intensive Aftercare ❑ OVWI ❑ Other _____

Treatment Start Date ___ / ___ / _____

Treatment End Date ___ / ___ / _____

Center Name _____

Notes (if you would like to explain any of your answers, you may do so in the Notes Sections)

_____

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Have you Experienced Any Abuse: Physical ❑ Mental ❑ Emotional ❑ Sexual ❑

Prior Abuse 1

Type of Abuse: Mental Physical ❑ Mental ❑ Emotional ❑ Sexual ❑

All of the above: ❑

Your Age (in Years When Abused)? _____

Who Abused You? Spouse ❑ Parent ❑ Step-Parent ❑ Grandparent ❑ Sibling ❑

Child ❑ Friend ❑ Stranger ❑ Employer ❑ Teacher ❑ Coach ❑ Doctor ❑

Other _____

Age of Abuser (in Years when you were abused) _____

Gender of Abuser Male ❑ Female ❑

How often did the abuse occur? _____

Notes (if you would like to explain any of your answers, you may do so in the Notes Sections)

_____

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Prior Abuse 2

Type of Abuse: Mental Physical ❑ Mental ❑ Emotional ❑ Sexual ❑
All of the above: ❑

Your Age (in Years When Abused)? _____
Who Abused You? Spouse ❑ Parent ❑ Step-Parent ❑ Grandparent ❑ Sibling ❑
Child ❑ Friend ❑ Stranger ❑ Employer ❑ Teacher ❑ Coach ❑ Doctor ❑
Other _____
Age of Abuser (in Years when you were abused) _____
Gender of Abuser Male ❑ Female ❑
How often did the abuse occur? _____

Notes (if you would like to explain any of your answers, you may do so in the Notes Sections)

_____
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Prior Abuse 3

Type of Abuse: Mental Physical ❑ Mental ❑ Emotional ❑ Sexual ❑
All of the above: ❑

Your Age (in Years When Abused)? _____
Who Abused You? Spouse ❑ Parent ❑ Step-Parent ❑ Grandparent ❑ Sibling ❑
Child ❑ Friend ❑ Stranger ❑ Employer ❑ Teacher ❑ Coach ❑ Doctor ❑
Other _____
Age of Abuser (in Years when you were abused) _____
Gender of Abuser Male ❑ Female ❑
How often did the abuse occur? _____

Notes (if you would like to explain any of your answers, you may do so in the Notes Sections)

_____
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Faith Profile

Do you have a Faith or Religious Affiliation? Yes ❑ No ❑

Faith Type: Christianity ❑ Islam ❑ Agnostic ❑ Atheist ❑ Hinduism ❑ Bhai ❑

Buddhism ❑ Judaism ❑ Bhai ❑ Unitarian Universalist ❑ Jehovah's Witness ❑

Morman/Latter Day Saints ❑ Catholic ❑ Eastern Orthodox ❑ Sikhism ❑ Spiritist ❑

Neo-Paganism ❑ Zoroastrianism ❑ Rastafarianism ❑ Atheist ❑

Other _____

Denomination: _____

Have you been Born Again through a Faith Confession in Jesus Christ? Yes ❑ No ❑

Are you Spirit-Filled? Yes ❑ No ❑

Do you Currently attend a Church? Yes ❑ No ❑

Name* _____

City* _____ State*_____

Church Phone ( ) ____-_____

Notes (if you would like to tell us more about your faith journey, you may do so here:

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Other Churches or denominations you have attended or been a member of in the past:

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Payment for Care

Funding Source 1

How do you plan to help pay for the program? Self-Funded ❑ Family/Friends ❑
Insurance ❑ Medicaid ❑ VA ❑ Local or Federal Government ❑ NGO ❑
Other _____

Contribution in Dollars* $_____
Contribution Frequency* One Time ❑ Daily ❑ Weekly ❑ Bi-Weekly ❑
Monthly ❑ Annually ❑
Notes (if you would like to explain any of your answers, you may do so in the Notes Sections)

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Legal Issues

Are you legally required to enter a recovery or treatment program? Yes* ❑ No ❑
**If yes, you must list the Legally Required Officer's Name below*
Treatment Required by Whom? Probation Officer ❑ Court ❑
Legally Required Officer's Name*_____

Are you under Legal Supervision Yes* ❑ No ❑
**If Yes, list the jurisdiction and how often you report in are required below, as well as your Probation Officer's Name*
Method of reporting to that supervision: Phone ❑ Letter ❑ In-person ❑
How often do you have to report in? Daily ❑ Weekly ❑ Monthly ❑
Probation Officers Name* _____
Jurisdiction* _____
Email* _____
Phone Number 1* ( ) ____-_____
Phone Number 2 ( ) ____-_____

Legal Supervision continued on next page

Supervision Contact Address*

_____

City _____State _____Zip _____

Have you ever been convicted of a sexual offense? Yes ❑ No ❑

If yes, are you a registered sex offender? Yes ❑ No ❑

If you have been convicted of a sexual offense, please explain what happened that led to your conviction: _____

_____

_____

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_____

Attorney's contact information

Attorney Name _____

Email _____

Phone Number 1 ( ) ____-_____

Phone Number 2 ( ) ____-_____

Address Line 1 _____

Address Line 2 _____

City _____State _____Zip _____

Are any of the following pending?

Warrant for Arrest ❑ Criminal Charges ❑ Court Appearance ❑ Sentencing ❑

Other _____

Please explain your history of arrest(s) and conviction(s):

Medical History

Medical History 1

**History should include Drug use, Alcohol use, Physical Disease/Ailments, Mental Health Issues*

Current Medications

History of developmental issues such as learning disabilities

Do you have Allergies to Medicine? Yes ❑ No ❑ Please list medications you are allergic to:

_____

_____

Do you have Allergies to Food(s)? Yes ❑ No ❑ Please list food(s) you are allergic to:

_____

_____

_____

Do you have Allergies to Anything Else? Yes ❑ No ❑ Please list other allergies:

_____

_____

Are you currently taking any psychotropic medications such as anti-depressants, anti-anxiety medications, stimulants, anti-psychotics, or mood stabilizers? Yes ❑ No ❑ Please list and explain why they have been prescribed: _____

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Physician 1 Information*

Physician Name _____

Why do you see this Physician? _____

Physician Email _____

Physician Phone Number 1 ( ) ____-_____

Physician Phone Number 2 ( ) ____-_____

Physician information continued on next page

Physician Address:

Address Line 1 _____

Address Line 2 _____

City _____State _____Zip _____

Physician 2 Information*

Physician Name _____

Why do you see this Physician? _____

Physician Email _____

Physician Phone Number 1 ( ) ____-_____

Physician Phone Number 2 ( ) ____-_____

Physician Address:

Address Line 1 _____

Address Line 2 _____

City _____State _____Zip _____

Do you use Tobacco? Yes ❑ No ❑

Will you need to detox? Yes ❑ No ❑

If yes, what will you need to detox from? _____

_____

_____

_____

Have you ever or are you currently experiencing suicidal thoughts? Yes ❑ No ❑

If you answered yes, please explain why: _____

_____

_____

_____

_____

_____

What is the condition of your teeth? Good ❑ Poor ❑ I don't know ❑

Health Insurance

Do you have Health Insurance Yes ❑ No ❑

If you answer "Yes", please fill in the information below.

Health Insurance 1

Health Insurance Type*

Primary ❑ Secondary ❑ Medicare ❑ Medicaid ❑ Prescription ❑

Provider* _____

ID Number* _____

Group Number* _____

Address Line 1 _____

Address Line 2 _____

City _____State _____Zip _____

Provider Email _____

Provider Phone Number ( ) ____-_____ Provider Fax Number ( ) ____-_____

Notes (if you would like to explain any of your answers, you may do so here):

_____

_____

Your Story

Please share a concise version of your story. Include how you heard about Adult and Teen Challenge (ATC), and why you think this is the right program for you.

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